

## NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

### NOTICE OF EXEMPT RULEMAKING

#### TITLE 9. HEALTH SERVICES

#### CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

##### PREAMBLE

- |                                    |                                 |
|------------------------------------|---------------------------------|
| <b>1. <u>Sections Affected</u></b> | <b><u>Rulemaking Action</u></b> |
| R9-22-101                          | Amend                           |
| R9-22-201                          | Amend                           |
| R9-22-205                          | Amend                           |
| R9-22-206                          | Amend                           |
| R9-22-217                          | Amend                           |
| R9-22-1412                         | Amend                           |
| R9-22-1434                         | Repeal                          |
| R9-22-1501                         | Amend                           |
| R9-22-1701                         | Amend                           |
- 2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**  
Authorizing statutes: §§ 36-2901.01, 36-2901.03(F), and 36-2901.06  
Implementing statutes: Laws 2004, Ch. 279, §§ 1 and 2
- 3. The effective date of the rules:**  
October 12, 2004
- 4. A list of all previous notices appearing in the Register addressing the exempt rule:**  
Notice of Exempt Rulemaking: 10 A.A.R. 23, January 2, 2004
- 5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**  
Name: Janette Quiroz  
Address: AHCCCS  
Office of Legal Assistance  
701 E. Jefferson, Mail Drop 6200  
Phoenix, AZ 85034  
Telephone: (602) 417-4698  
Fax: (602) 253-9115  
E-mail: AHCCCSRules@ahcccs.state.az.us
- 6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:**  
• Per Laws 2004, Ch. 279, § 1, AHCCCS is now required to re-determined member eligibility annually, rather than every six month.  
• Per Laws 2004, Ch. 279, § 2, the State Emergency Services Program has been repealed.  
• AHCCCS is exempt from regular rulemaking procedures per Laws 2004, Ch. 279, § 18.
- 7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**  
No studies were reviewed

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8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:  
Not applicable
9. The summary of the economic, small business, and consumer impact:  
Not applicable per A.R.S. § 41-1055(E).
10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):  
Not applicable
11. A summary of the comments made regarding rule, and the agency response to them:  
No comments were received.
12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:  
Not applicable
13. Incorporations by reference and their location in the rules:  
None
14. Was this rule previously adopted as an emergency rule?  
No
15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM  
ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section  
R9-22-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section  
R9-22-201. General Requirements  
R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services  
R9-22-206. Organ and Tissue Transplant Services  
R9-22-217. Services Included in the Federal Emergency Services Program

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

Section  
R9-22-1412. Review of Eligibility  
R9-22-1434. State Emergency Services Program (SESP) Repealed

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

Section  
R9-22-1501. General Information

ARTICLE 17. ENROLLMENT

Section  
R9-22-1701. Enrollment of a Member with an AHCCCS Contractor

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**ARTICLE 1. DEFINITIONS**

**R9-22-101. Location of Definitions**

**A.** Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"Accommodation"	R9-22-107
"Act"	R9-22-114
"Active case"	R9-22-109
"ADHS"	R9-22-112
"Administration"	A.R.S. § 36-2901
"Administrative law judge"	R9-22-108
"Administrative review"	R9-22-108
"Advanced Life Support" or "ALS"	R9-25-101
"Adverse action"	R9-22-114
"Affiliated corporate organization"	R9-22-106
"Aged" 42 U.S.C. 1382c(a)(1)(A) and	R9-22-115
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-107
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary department"	R9-22-107
"Annual assessment period"	R9-22-109
"Annual assessment period report"	R9-22-109
"Annual enrollment choice"	R9-22-117
"Appellant"	R9-22-114
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-114
"Auto-assignment algorithm"	R9-22-117
"Baby Arizona"	R9-22-114
"Basic Life Support" or "BLS"	R9-25-101
"Behavior management services"	R9-22-112
"Behavioral health evaluation"	R9-22-112
"Behavioral health medical practitioner"	R9-22-112
"Behavioral health professional"	R9-20-101
"Behavioral health service"	R9-22-112
"Behavioral health technician"	R9-20-101
"Behavior management services"	R9-22-112
"BHS"	R9-22-114
"Billed charges"	R9-22-107
"Blind"	R9-22-115
"Board-eligible for psychiatry"	R9-22-112
"Burial plot"	R9-22-114
"Capital costs"	R9-22-107
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-114
"Case"	R9-22-109
"Case record"	R9-22-109
"Case review"	R9-22-109
"Cash assistance"	R9-22-114
"Categorically-eligible"	R9-22-101
"Certified psychiatric nurse practitioner"	R9-22-112
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-112
"CMDP"	R9-22-117
"CMS"	R9-22-101
"Complainant"	R9-22-108

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"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	A.R.S. § 36-2901
"Copayment"	R9-22-107
"Corrective action plan"	R9-22-109
"Cost-to-charge ratio"	R9-22-107
"Covered charges"	R9-22-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CRS"	R9-22-114
"Cryotherapy"	R9-22-120
"Date of eligibility posting"	R9-22-107
"Date of notice"	R9-22-108
"Day"	R9-22-101
"DCSE"	R9-22-114
"De novo hearing"	42 CFR 431.201
"Dentures"	R9-22-102
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101
"DES"	R9-22-101
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disabled"	R9-22-115
"Discussions"	R9-22-106
"Disenrollment"	R9-22-117
"District"	R9-22-109
"DME"	R9-22-102
"DRI inflation factor"	R9-22-107
"E.P.S.D.T. services"	42 CFR 441 Subpart B
"Eligible person"	A.R.S. § 36-2901
"Emergency medical condition"	42 U.S.C. 1396b(v)(3)
"Emergency medical services"	R9-22-102
"Emergency services costs"	A.R.S. § 36-2903.07
"Encounter"	R9-22-107
"Enrollment"	R9-22-117
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Experimental services"	R9-22-101
"Error"	R9-22-109
"FAA"	R9-22-114
"Facility"	R9-22-101
"Factor"	42 CFR 447.10
"FBR"	R9-22-101
"Fee-For-Service" or "FFS"	R9-28-101
"FESP"	R9-22-101
"Finding"	R9-22-109
"First-party liability"	R9-22-110
"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"Federal poverty level" ("FPL")	A.R.S. § 1-215
"FQHC"	R9-22-101
"Grievance"	R9-22-108
"GSA"	R9-22-101
"Health care practitioner"	R9-22-112
"Hearing"	R9-22-108
"Hearing aid"	R9-22-102
"Home health services"	R9-22-102
"Homebound"	R9-22-114
"Hospital"	R9-22-101
"Intermediate Care Facility for	

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the Mentally Retarded” or “ICF-MR”	42 CFR 483 Subpart I
“ICU”	R9-22-107
“IHS”	R9-22-117
“IMD”	42 CFR 435.1009 and R9-22-112
“Income”	R9-22-114
“Inmate of a public institution”	42 CFR 435.1009
“Interested party”	R9-22-106
“LEEP”	R9-22-120
“Level I trauma center”	R9-22-2101
“License” or “licensure”	R9-22-101
“Mailing date”	R9-22-114
“Management evaluation review”	R9-22-109
“Medical education costs”	R9-22-107
“Medical expense deduction”	R9-22-114
“Medical record”	R9-22-101
“Medical review”	R9-22-107
“Medical services”	A.R.S. § 36-401
“Medical supplies”	R9-22-102
“Medical support”	R9-22-114
“Medically necessary”	R9-22-101
“Medicare claim”	R9-22-107
“Medicare HMO”	R9-22-101
“Member”	A.R.S. § 36-2901
“Mental disorder”	A.R.S. § 36-501
“New hospital”	R9-22-107
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)
“NICU”	R9-22-107
“Noncontracting provider”	A.R.S. § 36-2901
“Nonparent caretaker relative”	R9-22-114
“Notice of Findings”	R9-22-109
“OAH”	R9-22-108
“Occupational therapy”	R9-22-102
“Offeror”	R9-22-106
“Ownership interest”	42 CFR 455.101
“Operating costs”	R9-22-107
“Outlier”	R9-22-107
“Outpatient hospital service”	R9-22-107
“Ownership change”	R9-22-107
“Partial Care”	R9-22-112
“Party”	R9-22-108
“Peer group”	R9-22-107
“Performance measures”	R9-22-109
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	R9-22-102
“Prior period coverage” or “PPC”	R9-22-107
“Post-stabilization care services”	42 CFR 422.113
“Practitioner”	R9-22-102
“Pre-enrollment process”	R9-22-114
“Preponderance of evidence”	R9-22-109
“Prescription”	R9-22-102
“Primary care provider (PCP)”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Private duty nursing services”	R9-22-102
“Proposal”	R9-22-106
“Prospective rates”	R9-22-107
“Prospective rate year”	R9-22-107
“Psychiatrist”	R9-22-112

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"Psychologist"	R9-22-112
"Psychosocial rehabilitation services"	R9-22-112
"Qualified alien"	A.R.S. § 36-2903.03
"Quality management"	R9-22-105
"Radiology"	R9-22-102
"Random sample"	R9-22-109
"RBHA"	R9-22-112
"Rebasing"	R9-22-107
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-102
"Reinsurance"	R9-22-107
"Remittance advice"	R9-22-107
"Resources"	R9-22-114
"Respiratory therapy"	R9-22-102
"Respondent"	R9-22-108
"Responsible offeror"	R9-22-106
"Responsive offeror"	R9-22-106
"Review"	R9-22-114
"Review period"	R9-22-109
"RFP"	R9-22-106
"Scope of services"	R9-22-102
"SDAD"	R9-22-107
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
<del>"SESP"</del>	<del>R9-22-101</del>
"S.O.B.R.A."	R9-22-101
"Specialist"	R9-22-102
"Specified relative"	R9-22-114
"Speech therapy"	R9-22-102
"Spendthrift restriction"	R9-22-114
"Spouse"	R9-22-101
"SSA"	42 CFR 1000.10
"SSI"	42 CFR 435.4
"SSN"	R9-22-101
"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	R9-22-102
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
"Summary report"	R9-22-109
"SVES"	R9-22-114
"Third-party"	R9-22-110
"Third-party liability"	R9-22-110
"Tier"	R9-22-107
"Tiered per diem"	R9-22-107
"Title IV-D"	R9-22-114
"Title IV-E"	R9-22-114
"Tolerance level"	R9-22-109
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
"Unrecovered trauma readiness costs"	R9-22-2101
"Utilization management"	R9-22-105
"WWHP"	R9-22-120

**B.** General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A); and

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Meets license or certification requirements to provide AHCCCS covered services.

“Applicant” means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits.

“Application” means an official request for AHCCCS medical coverage made under this Chapter.

“Assignment” means enrollment of a member with a contractor by the Administration.

“Attending physician” means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a fee-for-service member.

“Capped fee-for-service” means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS-covered service or equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director.

“Categorically-eligible” means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) and 36-2934.

“CMS” means the Centers for Medicare and Medicaid Services.

“Continuous stay” means the period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

“Contract” means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

“Day” means a calendar day unless otherwise specified.

“DES” means the Department of Economic Security.

“Director” means the Director of the Administration or the Director’s designee.

“Eligible person” means a person as defined in A.R.S. § 36-2901.

“Enumeration” means the assignment of a specific nine-digit identification number to a person by the Social Security Administration.

“Equity” means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.

“Experimental services” means services that are associated with treatment or diagnostic evaluation that meets one or more of the following criteria:

Is not generally and widely accepted as a standard of care in the practice of medicine in the United States;

Does not have evidence of safety and effectiveness documented in peer reviewed articles in medical journals published in the United States; or

Lacks authoritative evidence by the professional medical community of safety and effectiveness because the services are rarely used, novel, or relatively unknown in the professional medical community.

“Facility” means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

“FBR” means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

“FESP” means a federal emergency services program covered under R9-22-217, to treat an emergency medical condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

“FQHC” means federally qualified health center.

“GSA” means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor.

“Hospital” means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

“License” or “licensure” means a nontransferable authorization that is awarded based on established standards in law, is issued by a state or a county regulatory agency or board, and allows a health care provider to lawfully render a health care service.

“Medical record” means all documents that relate to medical and behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that are kept at the site of the provider.

“Medically necessary” means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or prolong life.

“Medicare HMO” means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid for participation in the Medicare program under 42 CFR 417(L).

“Referral” means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

“Service location” means a location at which a member obtains a covered health care service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

“Service site” means a location designated by a contractor as the location at which a member is to receive covered health

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care services.

~~“SESP” means state emergency services program covered under R9-22-217 to treat an emergency medical condition for a qualified alien or noncitizen who is determined eligible under A.R.S. § 36-2901.06.~~

“S.O.B.R.A.” means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

“Spouse” means a person who has entered into a contract of marriage, recognized as valid by Arizona.

“SSN” means social security number.

“Standard of care” means a medical procedure or process that is accepted as treatment for a specific illness, or injury, medical condition through custom, peer review, or consensus by the professional medical community.

“Subcontract” means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;

A marketing organization; or

Any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to securing or fulfilling the contractor’s obligation to the Administration under the terms of a contract.

ARTICLE 2. SCOPE OF SERVICES

**R9-22-201. General Requirements**

A. No change

B. In addition to requirements and limitations specified in this Chapter, the following general requirements apply:

1. Only medically necessary, cost effective, and federally ~~and state~~ reimbursable services are covered services;
2. Covered services for the ~~state and~~ federal emergency services programs (FESP ~~and SESP~~) are under R9-22-217;
3. The Administration or a contractor may waive the covered services referral requirements required by this Article;
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member’s covered services. Delegation of the provision of care to a practitioner shall not diminish the role or responsibility of the primary care provider;
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor’s network without a referral from a primary care provider;
6. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from and in consultation with the primary care provider, or upon authorization by the contractor or its designee;
7. A member may receive a treatment that is considered the standard of care, or that is approved by AHCCCS Chief Medical Officer after appropriate consultative input from providers who are considered experts in the field by the professional medical community;
8. A member shall receive services according to the Section 1115 Waiver as defined in A.R.S. § 36-2901;
9. An AHCCCS registered provider shall provide covered services within the provider’s scope of practice;
10. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
  - a. A service that is determined by the Chief Medical Officer to be experimental or provided primarily for the purpose of research;
  - b. Services or items furnished gratuitously; and
  - c. Personal care items; and
11. Medical or behavioral health services are not covered services if provided to:
  - a. An inmate of a public institution;
  - b. A person who is in residence at an institution for the treatment of tuberculosis; or
  - c. A person age 21 through 64 who is in an IMD, unless provided under Article 12 of this Chapter.

C. No change

D. No change

E. No change

F. No change

G. No change

H. No change

I. No change

J. No change

K. No change

**R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services**

A. No change

B. The following limitations and exclusions apply to attending physician and practitioner services and primary care provider

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services:

1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
  - a. Qualification for insurance;
  - b. Pre-employment physical evaluation;
  - c. Qualification for sports or physical exercise activities;
  - d. Pilot's examination for the Federal Aviation Administration;
  - e. Disability certification to establish any kind of periodic payments;
  - f. Evaluation to establish third-party liabilities; or
  - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
3. Orthognathic surgery is covered only for a member who is less than 21 years of age;
4. The following services are excluded from AHCCCS coverage:
  - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
  - b. Pregnancy termination counseling services;
  - c. For federally funded programs, pregnancy terminations, unless required by federal law.
  - d. ~~For the state emergency services programs (SESP), pregnancy terminations that are not permitted by state law.~~
  - e. Services or items furnished solely for cosmetic purposes; and
  - f. Hysterectomies unless determined medically necessary.

**R9-22-206. Organ and Tissue Transplant Services**

- A. No change
- B. Organ and tissue transplant services are not covered for qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D) ~~or members of SESP under A.R.S. § 36-2901.06.~~

**R9-22-217. Services Included in the State and Federal Emergency Services Programs**

- A. General. For the purposes of this Section, emergency medical condition means a person in the ~~SESP~~ or FESP program is limited to services necessary to treat the sudden onset of a medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
  1. Placing the patient's health in serious jeopardy,
  2. Serious impairment to bodily functions, or
  3. Serious dysfunction of any bodily organ or part.
- B. No change

**ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS**

**R9-22-1412. Review of Eligibility**

- A. Except as provided in subsection (B), the Department shall complete a review of each member's continued eligibility for AHCCCS medical coverage at least once every 12 months.
  1. ~~Six months for a member determined eligible under R9-22-1420 and R9-22-1434;~~
  2. ~~Six months for a member determined eligible under R9-22-1421(3), except for a member under subsection (B)(4);~~
  3. ~~Twelve months for a member determined eligible under R9-22-1421(1) and (2), R9-22-1422, R9-22-1425, and R9-22-1426.~~
- B. The Department shall complete a review of eligibility for a:
  1. Pregnant woman determined eligible under R9-22-1421(1), following the termination of her pregnancy,
  2. Non-pregnant member approved only for emergency medical services at least once in a six-month period,
  3. Member approved for the MED program under R9-22-1427 through R9-22-1432 prior to the end of the six-month eligibility period,
  4. ~~Child under R9-22-1421(3) who has not attained 19 years of age and whose family income does not exceed 100 percent of the federal poverty guidelines, every 12 months;~~

~~5.4.~~ Any time there is a change in a member's circumstance which may affect eligibility.
- C. If a member continues to meet all eligibility requirements and conditions of eligibility, the Department shall authorize continued eligibility and notify the member of continued eligibility.
- D. The Department shall discontinue eligibility and shall notify the member of the discontinuance under R9-22-1413 if the member:
  1. Fails to comply with the review of eligibility,
  2. Fails to comply with the requirements and conditions of eligibility under this Article without good cause under 42

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CFR 433.148, or

3. Does not meet the eligibility requirements.

**R9-22-1434. State Emergency Services Program (SESP) Repealed**

**A. General Information:**

1. ~~The Department shall determine an applicant's eligibility for SESP when an applicant is not eligible under R9-22-1418 and:~~
  - a. ~~Meets the eligibility criteria under subsection (B), and R9-22-1405, R9-22-1406, R9-22-1410, R9-22-1416, and R9-22-1417, or~~
  - b. ~~Meets the MED eligibility criteria under R9-22-1427 through R9-22-1431.~~
2. ~~The following rules shall also apply under this Section: R9-22-1401 through R9-22-1404, R9-22-1407 through R9-22-1409, R9-22-1411(A), R9-22-1413 through R9-22-1415, R9-22-1419 and R9-22-1433.~~

**B. Income standard:**

1. ~~The family unit's countable income under this Section shall not exceed 40 percent FPL adjusted annually based on the number of persons in the family unit under A.R.S. § 36-2901.06.~~
2. ~~The Department shall consider the following to be a family unit for purposes of this Section:~~
  - a. ~~A single person without children;~~
  - b. ~~A married couple without children; or~~
  - e. ~~A MED family unit under R9-22-1428.~~
3. ~~The Department shall calculate income under R9-22-1419 or R9-22-1429.~~

**C. Notice for Approval or Denial.** ~~The Department shall send an applicant a written notice of the eligibility decision under this Section. This notice shall include a statement of the intended action, and:~~

1. ~~If approved under SESP, the notice shall also contain:~~
  - a. ~~The effective date of eligibility;~~
  - b. ~~A statement detailing the reason for the denial of full services;~~
  - e. ~~The legal authority supporting the decision;~~
  - d. ~~Where the legal authority supporting the decision can be found;~~
  - e. ~~An explanation of the right to request a hearing; and~~
  - f. ~~The date by which a request for hearing shall be received by the Department.~~
2. ~~If denied, the notice shall contain:~~
  - a. ~~The effective date of the denial;~~
  - b. ~~The reason for the denial, including specific financial calculations and the financial eligibility standard if applicable;~~
  - e. ~~Legal authority supporting the decision;~~
  - d. ~~Where the legal authority supporting the decision can be found;~~
  - e. ~~An explanation of the right to request a hearing; and~~
  - f. ~~The date by which a request for hearing shall be received by the Department.~~

**ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED**

**R9-22-1501. General Information**

**A. No change**

1. No change
2. No change

**B. No change**

**C. No change**

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change

**D. No change**

1. No change
2. No change
  - a. No change
  - b. No change
  - c. No change
3. No change
  - a. No change

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- b. No change
- E.** No change
- F.** No change
  - 1. No change
  - 2. No change
    - a. No change
    - b. No change
    - c. No change
    - d. No change
    - e. No change
    - f. No change
  - 3. No change
    - a. No change
    - b. No change
    - c. No change
    - d. No change
    - e. No change
    - f. No change
- G.** No change
  - 1. No change
    - a. No change
    - b. No change
    - c. No change
    - d. No change
    - e. No change
    - f. No change
    - g. No change
    - h. No change
    - i. No change
    - j. No change
  - 2. No change
    - a. No change
    - b. No change
    - c. No change
    - d. No change
  - 3. No change
    - a. No change
    - b. No change
    - c. No change
    - d. No change
    - e. No change
  - 4. No change
  - 5. No change
  - 6. No change
- H.** Processing of changes and redeterminations. If a member receives AHCCCS medical coverage under subsection (A), the member's eligibility shall be redetermined at least once every ~~6~~ 12 months or more frequently when changes occur under 42 CFR 435.916 which may affect eligibility.
- I.** No change
  - 1. No change
  - 2. No change
  - 3. No change
- J.** No change
  - 1. No change
    - a. No change
    - b. No change
    - c. No change
    - d. No change
    - e. No change
    - f. No change

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- g. No change
- 2. No change
- 3. No change
  - a. No change
    - i. No change
    - ii. No change
  - b. No change
  - c. No change
  - d. No change
  - e. No change
  - f. No change
- K. No change
  - 1. No change
  - 2. No change
  - 3. No change
- L. No change
- M. No change

**ARTICLE 17. ENROLLMENT**

**R9-22-1701. Enrollment of a Member with an AHCCCS Contractor**

- A. General Enrollment Requirements.
  - 1. Except as provided in subsections (A)(3), (A)(4), and (C), a member, determined eligible under this Chapter and residing in an area served by more than one contractor, shall have freedom of choice in the selection of a contractor serving the member's GSA within 16 days from the date of the initial interview. A Native American member may select IHS or another available contractor.
  - 2. If the member does not make a choice, the Administration shall auto-assign the member to IHS if the member is a Native American living on a reservation, a contractor based on family continuity, or the auto-assignment algorithm.
  - 3. The Administration shall enroll a member with the member's most recent contractor of record, if available, if the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days except if:
    - a. The member no longer resides in the contractor's GSA;
    - b. The contractor's contract is suspended or terminated;
    - c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
    - d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
    - e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
  - 4. The Administration shall not enroll a member with a contractor if a member:
    - a. Is eligible for the FESP under R9-22-1418 ~~or SESP under R9-22-1434~~;
    - b. Is eligible for a period less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;
    - c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with IHS;
    - d. Is not a Native American and resides in an area not served by a contractor; or
    - e. Is a Native American and resides in an area not served by a contractor or IHS.
- B. No change
- C. No change
- D. No change
- E. No change